Comments on Department HFS 117 Preliminary Report and Department Responses

Comment	Department Response
1. It is difficult to explain from my perspective how the actual cost of providing medical records to the patient is at a very reasonable schedule whereas the actual cost of providing medical records to non-patients (with the patient's authority) is at a very unreasonable schedule. In my experience where patients/plaintiffs give an unqualified authorization, there should be no different labor costs between the two requests. Obviously there is no different non-labor costs. Therefore, the schedules should be the same (at the lower schedule) or much closer. **1**	The Department agrees that the person making the request has no effect on the labor costs associated with the labor and non-labor costs of retrieving the records. The Department's distinction in fee limits between individuals (and their personal representatives) and all other persons is directly and solely driven by the Department's desire to conform the Department's rule requirements to federal HIPAA privacy regulations, which are applicable to most health care providers and which include certain copy fee restrictions. For copying of actual records (as distinguished from preparing explanations or summaries of records), the federal regulations provide at 45 CFR 164.524(c)(4) that individual patients (and, because of 45 CFR 502(g), their personal representatives) can only be charged for the cost of copying (including the cost of supplies for and labor of copying) and postage. A federal guidance document interpreting the HIPAA privacy regulations, published by the HHS Office for Civil Rights in December 2002, explains that, "The fee may not include costs associated with searching for and retrieving the requested information." In contrast, the Wisconsin statute language concerning the HFS 117 rule revision project, at s. 146.83 (3m) (a), allows but does not require such costs to be factored into the fees issued under HFS 117. The Department must structure the HFS 117 fee rules so that they comply with HIPAA. One possible approach to accomplish that would be to have HFS 117 fee maximums that are identical for all requesters, prohibiting a health care provider from charging a search or retrieval cost to any requester. An alternate approach is to have a two-tiered fee system with different fees depending upon whether the requester is the patient or personal representative (who can't be charged for the cost of search/retrieval because of HIPAA) or is some other requester (who can be charged). The Department has suggested the two-tiered fee approach. Consequently, the Department-proposed fee limit associated with an individual's or personal representative's request for a copy of medical records is much lower than the proposed fee limit for all others.
2. The fee schedule for records provided to non-patients seems too high. In fact, some of your supporting documents suggest the $21.00/$0.42 per page schedule is the highest cost estimates. Other more reasonable cost estimates were provided. Why weren't those estimates followed? Moreover, if that was an approximation of the actual costs, one must ask the common sense question of how businesses like SourceCorp and FYI Healthserve were able to stay in business, and actually turn a profit, by providing records at the current fee schedule of $8.40 per request or $0.45 per page for the first 50 pages and $0.25 per page for all pages over 50. **1**	The Department chose to propose the fee limit resulting from the highest cost estimates, but principally, at this point, for the purposes of illustration. As the Department noted on page 8 of the Report, "The Department considers the questions of whether the fee limit includes the added factors of "profit," "subsidization of some (less-than-actual-cost) requesters" and "off-storage costs" to be open and useful subjects for (advisory committee) members' comments." The Department will infer that the commenter does not think the "add-on" factors associated with "profit" and "subsidization" should be included in approximating the actual costs of complying with medical record requests. The Department cannot comment on the business practices of commercial entities, however, the Department speculates that requests for which those commercial entities receive that level of compensation represent only a fractional proportion of those entities' total requests. The Department further speculates that if, on the other hand,

	requests for which commercial entities receive the existing HFS 117 level of compensation are relatively more common, the commercial entities might be expected to charge requesters not subject to existing HFS 117 a higher rate in an attempt to compensate for what might be inadequate reimbursement for requests under HFS 117. Cross-subsidization is a common practice in medical care.
3. The most important revision to the proposed rule would be to HFS 117.05. I strongly recommend that the following language be added: Current: "If a patient or personal representative of the patient requests duplicate copies of the patient's medical records…" Revised: If a patient or personal representative of the patient requests uncertified or certified duplicate copies of the patient's medical records. Please have the committee consider this addition. This addition would satisfy a practical issue. **1**	Based on the input of an medical record maintainer on the advisory committee, th Department understands that there are costs associated with certifying medical records (see Department response to comment #25.) Consequently, the Department has proposed a fee limit of $7.50 to reflect an approximation of the actual costs of doing so. However, the Department remains interested in this issue and will consider any further information submitted by other committee members or commenters.
4. The committee should seriously consider returning to this subject in one year to audit and perhaps adjust the fee schedule. This would include having the Legislative Audit Bureau examine and analyze the accounting data for the businesses like SourceCorp and FYI Healthserve to ensure that the fee schedule best approximates the actual costs. **1**	The Department will consider this request. However, the Department's resources are especially constrained and the Department does not have the capacity to request projects to be undertaken by the Legislative Audit Bureau, given that the LAB is in a different branch of state government.
5. We are concerned that the proposed $3.20 per request and .04 per copy for HIPAA purposes is truly reflective of costs - it seems significantly too low. The non-HIPAA request scale seems more reasonable. It is possible that if there are two different cost scales, there could be the potential for most users to claim the lower category and possibly threaten through legal action, complaints, etc., against any medical record producer who does not honor the lower scale as the appropriate amount. **2**	The Department agrees that two different fee scales (particularly when one fee limit is a fraction of the other) increases the potential for most requesters to be the individual who is the subject of the records in order to obtain the lower rate. That may be an outcome of the two-tiered approach described in federal HIPAA policies and reflected in Department proposed rules. The Department believes that whether a two-tiered fee limit will prompt increased legal actions, complaints, etc. is an unknown.
6. The Department should consider utilizing some type of annual medical COLA factor (cost of living adjustment increases like we have in state law for gasoline taxes and noneconomic damage caps in WI) in between the Dept. reviews called for (every three years, I seem to recall?) **2** The Department failed to include any type of cost of living adjustment for the fees. An equitable way to achieve actual copy costs is to adjust for annual inflation. Over the past several years, inflation has increased in Wisconsin. One example of appropriately increasing costs based on inflation is the cap on non-economic damages. The cap was originally set at $350,000, but has increased to the current level of $410,322. It is anticipated that it will increase another 4% at the next annual adjustment. **2** Many states adjust their fee rates annually to reflect changes in the cost-of-	The Department will consider doing so, recognizing however, that the legislature directed the Department in s. 146.83 (3m) (b), Stats., to "revise the rules…to account for increases or decreases in actual costs" every ***three*** years.

living. Would there be an annual adjustment to the fees proposed in the Report? **4** Although DHFS will review copying costs every three years, that is not enough to ensure that physicians receive the actual cost of copies. The rule should allow for annual adjustments reflecting changes in the consumer price index for all urban consumers, US city average, as determined by the US Department of Labor. The Department would review the fees every three years in accordance with Wis. Stat. sec. 146.83(3m)(b) in addition to the annual inflation adjustments. **2**	The Department will consider the merits of basing its future inflation adjustments on a solely urban-derived CPI.
7. The fee of $3.20 and $.04 per page for individuals seems unreasonably low. These figures do not seem to accurately represent actual copying costs including supplies, etc. **2**	As documented in the data the Department cites in its report, the Department attempted to comply with its statutory directive to "prescribe fees that are based on an approximation of actual costs." However, for reasons described in the Department's response to comment #1, the fee limit for requests made by individuals is much lower. In addition, for the reasons described in the last paragraph of the Department's response to comment #9, the Department has revised its proposed fee limit for requests made by individuals to $0.20 per page.
8. If the rule sets a low fee for individuals, physicians will be placed in the position of rarely, if ever, receiving the true cost of copies. It's not reasonable for the Department to create an impossible situation for physicians and simply leave them to deal with the problems. **2**	The Department understands the commenter's concern about what she perceives to be the result of a relatively low proposed fee limit. However, the Department's proposal is driven by its desire to comply with both federal requirements expressed in the HIPAA regulations and the directives in Wisconsin statute. The Department's proposed revision of fee limits for requests from persons who are the subject of the records to $0.20 per page may address the commenter's concerns.
9. We are concerned that DHFS had the opportunity to address the higher cost of copying records on microfiche, but chose not to set a higher fee for records copied from that media. Although, the Department asserts that the percentage of microfiche records is only 12%, that seems significant enough to warrant an increased fee. It seems particularly appropriate to accord the higher fee for microfiche records, since the Department intends to reduce the copy fee as the use of electronic records increases (i.e. reaches 20%). The Department appears to be willing to lower the fees, but not address cost inequities that result from copying from more expensive media. **2**	Since, the Department is striving to propose a fee limit that's as reasonably reflective of actual costs as possible, the Department has reflected the additional costs of copying microfilm/fiche records by incorporating those added costs into its composite cost component-derived fee limits as described below. <u>Average Number of Records Per Request</u> On a related issue, and as discussed below and in the Department's response to comments #17, the Department accepts the opinion that the number of medical records per request should be 25 instead of 20. The 25% higher number would logically correspond to slightly higher numbers of minutes to comply with steps 6 and 7 of Appendix 1. Therefore, the Department has modified its estimate for step 6 of Appendix 1 (screening) to six minutes (instead of five.) However, the Department did not increase its estimate for step 7 (copying) by a full 25% (3 minutes) because of the significant variation in reported estimates for the task of copying records (discussed in footnote "h" to Appendix 1. Instead of increasing the estimated time from 12 minutes to 15 (25%), the Department added only a minute to its original estimate (now 13.) The Department believes that none of the other 12 steps should be appreciably affected by the 25% higher volume of records. Therefore, aside from incorporating recognition of the added time required to copy microfilm/fiche records, the Department's estimates for steps 6 and 7 are now 6 and 13 minutes.

	Incorporating Microfilm/fiche Into Calculations The only record reproduction cost component that appears to be significantly affected by working with the medium of microfilm/fiche is step 7 (copying.) The Department believes that the associated costs of all other steps/tasks would not be affected by the record medium. If one assumes that the proportion of microfilm/fiche records (reported to be 10-15%) net those of electronic records (reported to be 2-5%) is about **10%**, and the average amount of time to copy a microfilm record is **4 times**[1] the amount for a paper record, one can factor the added labor cost into the aggregate fee limit by multiplying the now 13 minutes attributed to step 7 in the "DHFS Estimates" in Appendix 1 by 4 (because step 7 may be expected to take 4 times longer for a microfilm record) and by assigning a weight of 0.9 to the paper-based estimate of 13 minutes and 0.1 to the microfilm/fiche-based estimate of 52 minutes for step 7 (on the assumption that screening and copying a microfilm/fiche record is 4 times more time-consuming than doing so for a paper record.) The factoring would be as follows: 13 min. x 0.9 (proportion) = 11.7 min.; 52 min. x 0.1 (proportion) = 5.2 min.; 11.7 + 5.2 = 16.9 (rounded to 17 minutes average to reflect the added labor cost associated with microfilm/fiche records. The additional 5 minutes (1 minute due to the increased time associated with copying 25 records instead the original presumption of 20, and 4 minutes attributable to reflecting the added impact of time required to copy microfilm records that are assumed to constitute 10% of the total records copied) would revise the average total required time to be 70 minutes instead of the 64 minutes average total required time previously stated in Appendix 1 of the preliminary report. As described in footnote "Q" to Appendix 1, 23 total minutes of aggregate variable labor costs (6 minutes for step 6 and 17 minutes for step 7) at $16.00 per hour equals $6.13; $6.13 divided by a 25-page average equals $0.25 per page (as opposed to the $0.23 currently reported under "DHFS Estimates" for "Labor Cost for Variable Expenses.") Consequently, the total labor costs becomes $12.53 + $0.25 per page. However, the minimum total cost (3rd row from the bottom of Appendix 2) ***remains*** $13.99 + $0.28 per page. The minimum total cost remains the same because, as explained in footnote "o" to Appendix 2, the Department's original estimate of $0.03 per page should have been $0.01. When calculating a fee limit for ***individuals'*** requests, using the revised 17 minutes attributable to the labor associated with copying would increase the allowable cost to $4.53 (for what is now assumed to be an average 25-record request.) To this amount, $0.02 per page is added to reflect copying supplies. However, the Department belatedly recognizes that the cost components allowable for requests made by individuals are comprised entirely of ***variable*** costs (labor for copying in step 7 plus the supply costs associated with copying.) Therefore, it is more appropriate to simply exclude a (fixed) "cost per request" based on an assumed average number of records in favor of a simple "per page" cost that reflects the variable copying costs allowable under HIPAA. If so, the fee limit for individuals would be ***$0.20 per page*** ($4.53 divided by a 25-page average for labor equals $0.18; plus $0.02 for supplies.)
10. The Department proposes to raise the cost of x-rays by $1 (from $4 to $5).	The Department currently has no information regarding what the "actual costs" of

That doesn't seem reasonable. The fee of $4 was set approximately 10 years ago. It is difficult to believe that even if you factor only the cost of inflation that the increase is only $1. According to the report, 15 states allow medical record maintainers to charge their actual costs to reproduce x-rays. The Department failed to provide any information regarding what those actual costs tended to be. Only 3 states imposed fees ranging between $1 and $8. Given the data, it is difficult to determine how the Department concluded that a new x-ray fee of $5 is appropriate. The revised x-ray fee does not seem reasonable (why not $8 or $15 or some other number based on data from those states that use actual costs?). **2**	reproducing x-rays are in any of the 15 states that allow such charges. In addition, the Department did not consider specifying that record maintainers can charge what they represent to be the actual costs of reproducing x-rays because the Department has been directed in statute to specify fee ***limits*** in administrative rule. Allowing record maintainers to charge whatever they represent as their actual costs is not a ***limit***. The limit of $4.00 for copies of x-ray records was specified in HFS 117 in 1992. In the 11 years since 1992, the national CPI has increased an average of 2.5 percent annually. Based on this inflation factor, what was $4.00 in 1992 becomes $5.25 in 2003. The Department has therefore modified its proposed fee limit to $5.25.
11. The Department weighed the question of whether to establish a lower fee for records copied by clinics, but decided not to do so. I believe that our physicians would agree that the fees that clinics charge for medical records should be at the same level as fees charged by hospitals and ambulatory care settings (not lower). If the Department considers a reduction for clinics in the future, we would vehemently object. **2**	The Department is not currently proposing a lower fee limit for clinics and physician offices, even though an officer of the Wisconsin Health Information Management Association thought the actual costs of clinic and physician office medical record reproduction were lower than that of hospitals.
12. It does not seem reasonable for the Department to define "health care provider records" to include patient billing statements. Wisconsin law requires the Department to develop copy fees for patient health care records. Wis. Stat. sec. 146.81(4) defines patient health care records. That definition does not specifically include patient billing statements. It seems to me that the Department's creation of a definition for "health care provider records" including patient billing statements exceeds the scope of the Agency's authority. The statute is unambiguous and the Department's rule exceeds the authority given to it by the Legislature. **2**	The language of s. 908.03 (6m) refers to "health care provider records" without a special definition. Section 146.83 (3m) refers to "patient health care records." Section 146.81 (4) defines "patient health care records" to mean "all records related to the health of a patient prepared by or under the supervision of a health care provider." The language of these statutes neither explicitly includes nor explicitly excludes billing statements, leaving the matter unclear. The Department is interested in comments from the committee on the advisability of including or excluding such records in the rule definition.
13. The creation of a fee schedule for patients significantly lower than the standard fee schedule seems problematic. The Department proposes a definition of "personal representative" as anyone who has authority under state law to act on behalf of the patient and qualifies as a personal representative under 42 CFR sec. 164.502(g). There is a typo in the federal rule, I presume the department intended to cite to 45 CFR sec. 164.502(g). **2**	The commenter is correct. The Department erred in its preliminary report when it repeatedly cited "4**2** CFR…" instead of the correct "4**5** CFR…"
14. In Wisconsin, a person authorized to act on behalf of the patient includes the parent, guardian or legal custodian of a minor patient, the guardian of an incompetent patient, the personal representative or spouse of a deceased patient, any person authorized in writing by the patient or a health care agent designated by the patient as a principal under chapter 155, if the patient is found to be incapacitated. If there is no surviving spouse of a deceased patient, then person authorized means an adult immediate family member. **2**	The Department's two-tiered fee approach is designed to compel the reduced fees only in categories of situations where HIPAA would require reduced fees. Health care providers have the discretion to voluntarily offer reduced copying fees; however, in order for a requester to be **entitled** to a reduced copying fee under HIPAA, the requester must either be the individual patient or be a person who falls within the HIPAA definition of "personal representative." The federal HIPAA definition of "personal representative" in 45 CFR 164.502(g) is not identical to the Wisconsin definition of "person authorized by the patient" in s. 146.81 (5), and the definition in that Wisconsin statute is not the only Wisconsin standard that could apply to a medical record situation. For example, s. 146.835 notes that parents who have been denied physical placement do not have the traditional parental authority relating to record access. The federal focus is on a person who can make health care decisions on

	behalf of the patient; in contrast, the Wisconsin definition in s. 146.81 (5) includes someone who has received the patient's consent for access to records. The intent of the proposed HFS 117 definition is to compel the reduced fee only when the requester is someone other than the actual patient who both qualifies to obtain record access under Wisconsin law **and** meets the "personal representative" definition under HIPAA. The Department is interested in any suggested rewordings of the fee rule definition to improve its clarity. See also the Department's response to the following comment.
15. The potential number of persons who could receive the records at the incredibly low rate ($3.20) is significant and places an undue burden on physicians. The statutory definition of "person authorized by the patient" might allow attorneys and others to circumvent the rule and obtain copies at the low cost. It is not clear to me that HIPAA (45 CFR sec. 164.502(g)) helps to restrict the potential number of people who might try to get the lower copy fee. **2**	As indicated above, a "personal representative" as defined in HIPAA is not the same thing as the Wisconsin definition of "person authorized by the patient." To maintain consistency with the federal HIPAA regulations and policy interpretations, the Department desires that HFS 117 clearly specify that the lower "individual" fee limit does not apply to an attorney requesting a client's medical records. The Department's position is strongly influenced by federal commentary responding to a comment on page 53254 of the August 14, 2002 Federal Register. In the response, the federal government clarifies that the limited cost components specified under 42 CFR 164.524(c)(4) apply ***only*** to individuals' and individuals' personal representatives' requests for copies of individuals' medical records. It also states that "The fee limitations in 164.524(c)(4) do not apply to any other permissible disclosures by the covered entity, including disclosures that are permitted for treatment, payment or health care operations, disclosures that are based on an individual's authorization that is valid under 164.508, or other disclosures permitted without the individual's authorization as specified in 164.512."
16. The commenter related being billed $20.95 for one page. He pointed out that under the rule language contained in the Department's preliminary report, the same request would have cost him $21.42. He questions whether the Department's proposed fee limit is reasonable. He further asks the hypothetical of whether any individual client might be expected to object to such a fee. **1** We think the proposed fee increases are excessive. **6**	The Department understands that the Department's proposed fee limit seems extremely high. However, everyone must bear the following in mind: 1. The legislature directed the Department to develop fee limits that are "realistic estimates of actual patient record reproduction costs based on an approximation of pertinent costs associated with accomplishing such reproduction." Ample data, referenced in the Department's preliminary report, illustrate that responding to a request for copies of a medical record is not as simple as pulling a 8x11 or 8x14 inch piece of paper from a file drawer, placing it on a standard photocopier, and punching a button. If it were, calculating an associated fee limit would be much easier, as the bulk of the costs are *variable*. Indeed, as detailed in Appendices 1 and 2 of the Department's preliminary report, most of the costs associated with responding to a request for medical records are *fixed* insofar as they are required regardless of the volume the medical record provider must respond to, whether the request results in one copy being made or 100. However, if committee members or other commenters provide cost information that contradicts that relied upon by the Department in formulating the preliminary fee limits, the Department will review that information and consider revising the preliminary amounts. 2. If a client does not like (or, in the practitioner's opinion, may object to) charges resulting from the application of the HFS 117 fee limits, the practitioner may consider communicating to his or her client the nature of the HFS 117 fee limits and give the

	client the option of requesting his or her own records, in which case, under the Department's preliminary two-tiered system, would cost the client less. Whether the client thinks such discrepancies to be unreasonable and significant may be expected to vary among clients. 3. The commenter should bear in mind that HFS 117 specifies fee *limits*. Nothing prevents a medical record maintainer from charging less than the lawful fee limit.
17. I believe the average number of pages is closer to 30 pages. I base this on the fact that computerization has increased the amount of information available thereby generating more reports resulting in more pages. In my twenty-two years in health information, I have witnessed the growing of records. I was reviewing the HIPAA Privacy Rule and on page 82273 of the December 2000 preamble it states that the average medical record is 31 pages. **3** AHIOS members believe that the average request results in at least 25 pages. **4**	The Department believes the commenter's information is persuasive in its citations and logic. In other words, the Department's believes it is reasonable to assume a somewhat higher amount as an average. In fact, another record copying service reported the average request to be for 23 pages. Therefore, the Department has raised its estimate of the average to 25 records. Doing so adds a minute to the Department's estimate for step #6 in Appendix 1 (screening) of the Department's report. Given the variability is reported estimates for the copying cost component (step #7), the Department has proposed adding only 1 minute (instead of 3) to step #7 due to the increase in average number of records from 20 to 25. However, to reflect the fact that 10% of records are microfilm/fiche, the Department has also added 4 minutes to the estimated average amount of time step #7 takes to complete. That additional amount of time, however, is partially offset by apportioning those imputed added labor costs among more records (now 25.) Therefore, the labor costs for variable expenses has increased only $0.02 per page (and is completely offset by the Department's downward adjustment of its estimate of copier supplies costs (toner and drum replacement) in Appendix 2, as discussed in footnote "o" of Appendix 2.
18. Would the Department consider allowing a separate charge for off-site storage or microfilm processing? **3**	The Department would consider doing so under two assumptions: first, that such storage costs are a reasonable business practice; and second, a persuasive rationale for why the $0.84 a request as an approximation of required "physical space" as a cost component in Appendix 2 is not sufficient reflection of medical record storage. If both of the preceding assumptions are the case, there must also be some reasonable and reasonably accurate way of approximating and reflecting such storage costs.
19. Sales Tax needs to be applied to these requests and I think it should be outlined in the rule as some providers and attorneys were not aware of this until the past few years. **3** The Wisconsin Department of Revenue has ruled that sales tax must be collected for any charges for the provision of copies of patient health care records. Can the rule be modified to clarify that sales tax must be collected? **4**	The Department has added a note to requesters in the rule. The substance of the Department's rule itself has no bearing on whether or not sales tax is applicable and nothing the Department says in the rule affects the current or future reality of requirements. Therefore it would be inappropriate for the Department to allude to sales tax in the substantive provisions of the rule.
20. The hourly wage for the Department of $16.00 is low. Does this include benefits? $4.00 or 20% is a significant difference when considering 2080 hours of work a year. **3**	The $16.00 average hourly labor compensation rate was explicitly stated to include consideration of benefits. Moreover, a committee member from Wauwatosa, a suburb of Milwaukee, made the estimate. Whether the assumed salary should be raised to, e.g., to $20, may be a topic for the committee to address.
21. The proposed "per page" portion of the fees are very low. The state of	Assuming the commenter is referring to the fee limit of $0.04 per page proposed for

Oklahoma has the lowest fees in the country at 25 cents/page. The numbers proposed in the Report are comparable and will result in facilities picking up the difference between the uniform fee and the true cost of providing the service. **4**	requests made by individuals, the Department has revised its approach to specifying the fee limit for complying with requests made by individuals, as described in the last paragraph of the Department's response to comment #9. In sum, given that all of the allowable activities that are recognized/allowable for complying with an individual's record request (labor cost for step #7 in Appendix 1 of the preliminary report plus the "paper" and "copier supplies, toner, drum replacement" supply costs associated with the copying in Appendix 2) are ***variable*** costs, the Department believes it is therefore reasonable to specify a fee limit consisting solely of a per page fee limit. As also described in the second paragraph of the Department's response to comment #9, that fee limit becomes $0.20 per page. Twenty cents per page, coincidentally, is much closer to the cited Oklahoma fee of $0.25 per page.
22. The fee proposed for the patient and patient representative requests has not been properly constructed. According to HIPAA, this fee must be "a reasonable cost-based fee provided only the cost of copying and postage" are included. The Report's proposal attempts to meet this test. Unfortunately, the commentary on HIPAA clarifies that only a "per page fee" can be applied to requests from patients and patient representatives. The HIPAA commentary specifically states that "no retrieval, clerical, or administrative fee can be charged." **4**	The Department has for different, but complementary, reasons revised its structure of fee limits for individuals to one that consists solely of a *per page* charge.
23. Can there be clarification that the stated per page fee can be charged for ALL pages provided to the requestor? **4**	Since it was the Department's intent that the per page fee limit applied to all pages provided to the requester, the Department has made that fact explicit in its proposed rules.
24. Which requests for duplicate patient health care records would be covered by the proposed rule? Would all of the following examples be covered? a. Requests from the Bureau of Social Security Disability? b. Requests for certified copies of records? c. Requests from those who are considering underwriting health and/or life insurance? d. Requests from property and casualty insurance companies which are reviewing claims? e. Requests from health insurance companies which are reviewing claims? f. Requests from attorneys who are deciding whether to represent a potential client? g. Requests related to worker's compensation claims? **4**	The Department believes that given the placement and wording of ss. 146.83 (1) and 908.03 (6m), Wis. Stats., the legislature intended the fee limits specified in HFS 117 to apply to all record requests that take place under either one of those statutes, except when a special fee limit is expressed in some other state or federal law for a particular situation. The Department tried to make that point in the language it proposed for HFS 117.02. As indicated in the note to HFS 117.02, the worker's compensation system is an example of a program that has special fee limits, which happen to be imposed by statute under s. 102.13 (2) (b) and which will frequently be encountered by health care providers. Those limits clearly supersede HFS 117. If a requester believes that some special fee is applicable that happens to be lower than the HFS 117 limits, the requester will undoubtedly bring that to the attention of the health care provider.
25. The certification of records requires that extra effort must be expended by the records maintainer. Can a certification fee be established? This certification fee would be in addition to the proposed fees. **4**	In keeping with the Department's attempt to approximate the actual costs of medical record reproduction, if a record maintainer's certifying records entails significantly additional effort, the Department believes that such effort should be reflected in the fee limit. To do so, the Department would need to know the nature of the "extra effort" associated with certifying records. Is it a fixed effort that does not appreciably vary regardless of the number of records involved, or does the effort vary as a function of

	the number of records involved? If the former, the associated expense would be added to the eventual "per request" component of the fee limit under HFS 117.05 (2). If the latter, the associated expense would be added to the eventual "per page" component of the fee limit under HFS 117.05 (2). In either event, the Department would need a reasonable estimate of the time required to certify records. Toward this end, the Department asked several advisory committee record maintainer representatives for information related to these issues. In response, the Department was told that record certifications are performed by management personnel (thereby entailing a higher compensation rate, e.g., $26-30/hour) and that the review, QA and record certification takes an average of 10-20 minutes. Accordingly, the Department proposes adding a fee limit of $7.50 to each request for "certified" records ($0.50 per minute compensation times 15 minutes) and has amended HFS 117 to reflect that cost. However, the Department remains interested in this issue and will consider any further information submitted by other committee members or commenters.
26. Undoubtedly, insurance companies and attorneys will attempt to take advantage of the provision in HIPAA which allows for patients to obtain records at actual product cost. In fact, I have already seen letters from attorneys to their clients outlining the need for them to request the records themselves in order to get cheaper rates. While I feel this a huge loop hole in the Privacy Rule that can be used to usurp state law, I feel that were Wisconsin to establish standards as stated in the preliminary report it would only add credibility to this method of removing the individual states' jurisdiction on medical record fees for legal and insurance purposes. My reason for this concern is clearly self serving, yet I feel quite valid nonetheless. Beyond my position in this industry and environment the main two reasons this must be avoided at all cost is two fold. One, the Privacy Rule clearly states that the patient or patients' representative can receive records upon payment based on actual product cost. However, the Rule also clearly defines what a patients' representative is, neither attorney nor insurance company is included in this definition. Allowing for attorneys and insurance companies to be the ultimate recipient of medical records in which HIPAA mandated patient rates are charged was not the intention of this provision, nor should any state create standards by which this action is made to be a simpler process. Secondly, making the assumption attorneys et al will use this provision to obtain records (and they will as evidence by the letter from the attorney to his client which we obtained) the release of information industry will not only be devastated it will be destroyed. Companies such as ours will not only be unable to operate of a profit, we will be unable to pay our employees and will go out of business. While some may see this as a good thing, rest assured the medical facilities would then be forced to assume this cost and it would be equally as destructive for them. In short, this would disrupt the rather smooth	The commenter raises an interesting point. However, the Department has no control over the structure of the federal HIPAA provisions. Nothing in the HIPAA regulations prevents a patient or personal representative from obtaining a copy of records and then providing that copy to someone else. The HIPAA regulations do not limit the purpose of the patient or personal representative in seeking records. Accordingly, the Department lacks authority to specify in the HFS 117 rules that a patient or personal representative is eligible for the lower fee only if he or she keeps the records for personal use.

flow as it exists today in the release of information industry. Before copy services existed, medical providers could not meet release of information demands resulting in huge backlogs. Sure, if today's provisions eliminate my industry it would only be a matter of time before medical providers face a similar situation and routinely violate HIPAA standards for turnaround time. This would just lead the cycle back to the need for ROI providers. It need not get to that point. This being said, what is the solution? I feel it is quite simple. One, I hope that there will be reversal or clarification of this provision at the federal level. Such a thing would of course render my current concerns with your department moot. Two, were this not to occur, the department must be very careful in the wording used in the code. Instead of stating patients must only pay x amount for any purpose and letting the chips fall where they may, I feel it would be prudent to include language that would specify that those rates only apply for strictly personal purposes, such as keeping a personal file or review of one's record. The rule should state that these reduced rates do not apply for legal or insurance purposes. In fact, rather than basing the fees on who the requestor is, the fees should be based on the purpose for the request. This would be quite practical and easily discernable as a HIPAA requirement for authorizations includes that the purpose for the request must be given (on these authorizations there are areas to check insurance, legal, personal, medical care, etc). While the patient could still be misleading and say personal when its not (this would be impossible to enforce), in all likelihood they would be honest and indicate the actual purpose. This being the case, a rule based on the purpose of request rather than who the requestor is I feel would more closely resemble a standard as intended by HIPAA rules. While there is no silver bullet as long as this HIPAA provision remains unchanged, I feel this would be the most fair and accurate decision to make at the state level. Of course people will still try to find loopholes; attorneys will have patients request records and indicate personal purpose even as they do today; but why should we create a rule which simply makes this loop hole larger? **5**	
27. The proposed fee structure creates confusion and raises the question: "What is the actual cost of duplicating medical records?" Is it $3.20 plus 4¢ per page or $21.00 plus 42¢ per page? **6**	The Department's estimated approximations of actual costs of duplicating medical records are stated in the last three rows of column three in Appendix 2. The lowest estimate proposed is $13.99 + $0.28 per page. That estimate does not reflect either "profit" or ""subsidy." A fee limit of $15.38 + $0.31 per page reflects incorporating a 10% profit. The fee limit of $20.99 + $0.42 per page reflects incorporating both a 10% profit and 40% subsidy. A fourth (unstated in Appendix 2) option is $19.59 + $0.39 per page, which reflects incorporating only the 40% subsidy. The Department believes that the question of whether to incorporate recognition of particular "profit" or "subsidy" factors is the most significant outstanding issue in the revision of HFS 117, and would appreciate advisory committee members' and other

	commenters' thoughts on the matter.
28. The proposed increases for non-patients are not consistent with the current rate structure and represent an unwarranted increase in fees. We recommend DHFS review and compare any fee structure with cost of living increases for the last decade. We propose a fee structure similar to the current fee structure; the greater of a set amount or a cost per page, which does not contradict HIPAA regulations or include a retrieval fee charge. **6**	The Department understands that the proposed fee limit structure is not the same as the current rate structure. At no point did the Department accept and state as a given that revisions to HFS 117 must be consistent with the structure in existing HFS 117. Neither did the Department understand that its statutory directive or proposed approach be that of simply revising the existing HFS 117 fee structure and limits to reflect inflationary increases in the cost of living over the past 11 years. Adhering to the approach of approximating actual costs suggests developing or using a cost model that approximates current reality. The Department compared the fee structure and limits of other states and found that most states use some combination of fee limit per request, fee limit per page, or both. The Department's proposal has similar characteristics. With respect to HIPAA's impact, the statute language enacted in Wisconsin contains explicit language in s. 146.83 (3m) (a) indicating that the Department's rules ***may*** consider the cost of retrieval of records. That is, the Wisconsin legislature endorsed (although did not require) including such costs in the fee limit. However, HIPAA prohibits charging the individual patient or personal representative for that activity. If the Department were to specify a single fee structure, in order to comply with HIPAA, that fee would of necessity have to prohibit including any cost of retrieval in the calculation. The Department could indeed do that and still be in compliance with s. 146.83 (3m), but it would appear to be inconsistent with the legislative endorsement of charging for the cost of retrieval. That leaves the Department with a two-tiered system.
29. We believe the legislation's goal was to create one fee structure for all requests for medical records, not establish a two-tiered fee structure for different parties. It was also the intent of the legislation to try and rein in costs associated with paying for duplicate medical records. **6**	Neither ss. 146.83 (3m) or 908.03 (6m) directs the Department to specify one fee structure for all medical records requests. The Department did not promise that there would be a single fee limit system for all requesters rather than a two-tiered fee limit system. The Department is aware that negotiations took place for a long time on what sort of statutory fee system would be acceptable. If any interested party can produce something in writing from a legislative committee or describing intent of the legislation, the Department will consider it. Thus far, nothing has been supplied. The Department must also take into account the situation under HIPAA.
30. The proposed rule creates confusion. The two-tiered fee structure proposed presents a myriad of concerns. For example, in many cases, whether it is dealing with a car accident or social security disability requests, a person comes to a law office and signs a medical authorization request. The authorization form is sent to the medical provider along with a letter from the attorney requesting the medical records. Who is requesting the records, the patient, who authorizes the release or the attorney who wrote the letter? It is very important to remember that it is the patient who ultimately pays for the records. The attorneys do not pay for the cost of getting the records. The cost is passed on to the client/patient. Why in one circumstance does the patient pay $3.20 plus 4¢ a page, but in another circumstance the patient pays $21.00 plus 42¢ a page? Under the proposed scenario what happens if the patient	The requester is the person or entity that transmits the request to the health care provider. If the patient signs a form authorizing an attorney to obtain records, gives the signed form to the attorney, and the attorney then sends the authorization to the health care provider along with a request that the health care provider give the attorney the records, the requester is the attorney. If the patient makes the request directly to the health care provider, the requester is the patient. While this may be problematic, the Department believes it is the inevitable result of the HIPAA language. The Department must attempt to comply with the language.

sends a letter and asks for the records to be sent to an attorney's office; which party is requesting the records, the patient or attorney? What happens if the medical records are requested by the patient who asks that they be sent to an attorney's office and the attorney pays for the copies, who "requested" the records? **6**	
31. A concern is the limitation on the definition of "personal representative." Wisconsin has specifically enacted a Power of Attorney for Health Care statute (chapter 155.) The person is empowered to act on behalf of an incapacitated individual. Under the current fee proposal, would the power of attorney for health care have to pay $21 plus 42¢ a page for the medical records of the incapacitated person? **6**	A health care agent acting under an activated power of attorney for health care document qualifies for the reduced fee if the health care agent is the records requester. That person has explicit authority under Wisconsin statutes in ch. 155 to make health care decisions on behalf of the patient and access health records of the patient, and also falls within the federal definition of "personal representative" in the HIPAA regulations. If a health care agent merely signs an authorization form allowing disclosure of records to a third party and it is the third party who is the records requester, then the third party record requester does not qualify for the reduced fee.
32. We certainly object to the inclusion of profit and subsidization costs in the proposed fee structure. Why should a profit-making business be subsidized and guaranteed a profit? We do not believe profit and subsidization are part of the actual cost of duplicating medical records. It is the company's business decision to charge less for medical records to certain groups or businesses. We believe this practice has contributed to the current fee schism, charging little or nothing to some groups or individuals while overcharging others, and why members of our organizations are upset by current charges for medical records. **6**	As described in the Department's response to comment #27, at this point, the Department has only proposed several fee limits that correspond to recognition of "profit" and "subsidy" factors. The Department believes it this subject merits discussion by the advisory committee.
33. Records requests for persons seeking eligibility for means-tested governmental benefit programs seem to fall somewhere between the "patient/patient's personal representative" and "other entities" requesting records. We believe the rules need to provide a third category with capability for alternate fee structures for federal and federal/state eligibility programs where the fee schedule is not in law, but rather is driven by federal government budgeting oversight. If this is not feasible, we would recommend the applicability of the rule not include records requests for government program eligibility determinations. We would also suggest that the rule not dictate for the disability program the process for the records request as we must follow federal program policy in this regard. **7**	The two-tiered fee structure is the result of the federal HIPAA requirements. HIPAA does not give a special copy fee break to anyone other than the individual patient or "personal representative," as defined in the HIPAA regulations If some other state or federal law applicable to a variety of record request contains its own fee limits, those fee limits would supersede the proposed HFS 117 fee limits, as is indicated in HFS 117.02. The health care provider can also reduce or waive fees pursuant to a contract with a record requester, or simply because of the health care provider's own volition. The HFS 117 rules are ***maximum*** fees, not ***minimum*** fees. There are no procedures expressed in the HFS 117 rules other than the obvious need for the requester to appropriately articulate whose records are being sought and to assure the health care provider that the requester qualifies to obtain them.
34. While the current record keeping by electronic files is a relatively low percentage, consideration should be given to more than just electronic record files. The Social Security Administration is rapidly moving to electronic record claims files. We are actively working with record sources on electronic record creation as well as electronic transmission from paper records. One major	The Department will consider including electronic disclosures as a fee category if specific details are provided for appropriate review of the situation. The fee rules are intended to be based upon actual cost information and cannot speculate what might happen at some unknown future occasion. The Department will review the rules more frequently than every three years if circumstances warrant a shorter review period.

release of information company with contracts with hundreds of medical facilities nationwide already offers us this service through a web-based access, and we believe more of these companies will move to this method during the next year. We believe the rules should now reflect the efficiencies and potential cost differences in these situations rather than waiting for the update review in three years. **7**	

Footnote

[1] Dunn reported in her 1997 article that copying microfilm took 4-5 times longer than copying paper documents. Two medical record maintainers estimated that copying microfilm took 3-4 times longer. A representative of entities that reproduce medical records estimated "at least 4 times" longer. The Department is using an estimate of 4 times longer.

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